Provider Nomination Form

PLEASE FAX THIS FORM TO:
PROVIDER RELATIONS DEPARTMENT (513) 765-3024 fax
OR MAIL TO: PROVIDER RELATIONS DEPARTMENT
ATTN: PROVIDER RECRUITING
4000 LUXOTTICA PL
MASON, OH 45040

During open enrollment, if you discover your current provider is not in the provider network, please forward this form to Provider Relations for recruitment. However, please note that the submission of this information does not guarantee that your doctor will become a provider. If your provider chooses to not participate in the network, you may still eligible to receive out-of-network benefits with this provider.

Please complete the following information. Print clearly.

Date: _____

Doctors Name: _____
Name of Facility _____

Address: _____

City/State: _____

Zip Code: _____

Phone Number: _____

Provider Type: **Ophthalmologist** ☐ **Optometrist** ☐ **Optician** ☐

NOTES:..

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PLAN TYPE: **EM** _____

GROUP NAME: **NA** _____